DesMoinesRegister

California's pool outperforms Iowa's

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Written by

The Register's Editorial

Last week the Los Angeles Times reported California had enrolled 6,000 patients in its federally funded high risk insurance pool. How is it doing things differently than Iowa?

It launched an aggressive and targeted ad campaign to attract enrollees. It spends a much smaller percentage of its money on administration. Unlike Iowa, it allows "third-party payers" to help pay premiums for HIV-positive residents there.

Those overseeing California's program are also accountable to the public. Board calendars, agendas, minutes from meetings and contact information for members are all easily accessible online. Compare that to Iowa where residents can't even find out who sits on the board, let alone when a board meeting is going to be held. None of the information is online. In Iowa, no one other than board members is informed about coming meetings.

California administrators actually want to get residents insured. "We are going full speed until the federal government tells us to stop," the executive director of California's program told The Des Moines Register Opinion page staff.

Those who oversee Iowa's program have refused to change a policy that would allow an estimated 100 HIV-positive Iowans to sign up. If these Iowans lived in California, they would be getting help.

PULLING IT TOGETHER...

from Drew Altman, Ph.D., President and CEO

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2012: The ACA, and More

What is remarkable about 2012 (and the current era in health policy) is how many big health policy issues and marketplace changes will be in play at the same time:

- **HEALTH REFORM:** There is the implementation of a historic but fragile health reform law, with a Supreme Court decision pending and so much hanging in the balance.
- **MEDICARE AND MEDICAID:** There are continuing debates about potentially big changes in Medicare and Medicaid, driven by the desire to reduce the deficit. With the collapse of the Super Committee triggering big cuts in defense and with the Bush tax cuts set to expire, there will be pressure to make a new deal to meet budget targets that protect defense spending and preserve at least some of the tax cuts. Complicating matters is the pressure to avoid major cuts in Medicare payment rates for physicians when the short-term "doc fix" expires. All this could cause policymakers to look again at savings and changes in Medicare and Medicaid, as well as the Affordable Care Act (ACA). While health reform attracts the most attention, these two public programs cover more than one hundred million low-income, disabled and elderly Americans. And, Medicare is unique as a health issue because, despite the clamor about health reform, it is the one health issue proven to move votes.
- **OUTSIDE THE BELTWAY:** Then there are the changes occurring outside the beltway. Faced with lingering budget pressures and the expiration of enhanced federal matching payments, states continue to cut back their Medicaid programs (mostly through provider payment reductions, since maintenance of effort rules prevent cuts in eligibility). States are also cutting other programs and services for low-income people. The health care delivery system continues to morph and change rapidly with mergers, consolidations, Accountable Care Organization (ACO) mania, and more. The insurance system continues to change as well. Insurers are experimenting with new payment arrangements while insurance itself is becoming less comprehensive with the growth of high-deductible plans. People continue to be hard-pressed by their out-of-pocket health care costs. Strikingly, the Census recently reported that the biggest factor driving people into poverty was their out-of-pocket health costs.
- **THE ELECTION:** Last, and potentially most significant of all, there will be an election in 2012. Elections matter hugely for policy directions, if not always substantive legislative changes, and quite obviously, if President Obama is unseated by any of the Republican candidates (and especially if the Senate changes hands at the same time), the direction of health policy could fundamentally change.

This graphic summarizes how much could be in play in 2012:

2012: Everything in Play?

Health Reform	What will the Supreme Court do? Will implementation in the states gain/lose momentum?
Medicare, Medicaid and the Deficit	Will the "trigger" trigger a new budget deal?
The States	Budget pressures continue. Will states cut? What? How much?
The Delivery and Insurance Systems	Mergers continue? Payment reforms kick in? Continued growth of high-deductible plans?
The Election	Stay the course or a change in direction for health policy?

There is a tendency to think of this period in health policy as the early ACA years. To be sure, the ACA has and will make fundamental changes in the health care system. No doubt it is the new big thing and the big story. But it alone is not what is most remarkable about this year or the current era in health policy. What is unusual about 2012 is how many programs, issues, and changes are in play all at once.

It is entirely possible that the court will uphold the law; nothing much will be done to "reform" (some would say harm) Medicare and Medicaid, despite budget and political pressures; and the President will be re-elected and policy directions will continue largely unchanged. Or, it may be that some of these tipping points will tip and others will not. Big changes or small, policy is generally better when it is informed by facts and analysis and made more accountable by good journalism. And no matter what happens in Washington many of the changes in payment and delivery unfolding in the marketplace will continue, and they warrant real assessment to determine if they are merely the latest fads, or if they represent real progress.

For journalists it will be a target-rich environment. But with such a broad health policy beat, journalists will need to make choices about which stories to cover, and they will be hard pressed to get beyond the beltway where many of the most important stories will be found. It will be a challenging year for analysts too. There is a need for data and analysis on such a wide range of issues, and it will need to be generated in real time to be relevant and useful. Assessing the changes occurring in the marketplace is always a special challenge, because up-to-date data on the private market are difficult and sometimes impossible to find.

At Kaiser we will do our best to provide explanation, data and analysis, polling, and in-depth journalism, on as many of these issues as possible. And we will keep our eye on our special focus: the impact policy debates and marketplace changes have on people.

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Growth in U.S. Health Spending Remains Slow in 2010

Health spending growth at historic lows for second consecutive year

U.S. health care spending experienced historically low rates of growth in 2009 and 2010 according to the annual report of national health expenditures (NHE) published in the January issue of the journal *Health Affairs.*

Analysts at the Centers for Medicare & Medicaid Services (CMS) report in the article that the increase in spending for 2009 represents the lowest rate of increase in the entire 51 year history of the NHE. The low rate of growth, the data show, reflects lower utilization in health care than in previous years. The report notes that U.S. health care spending grew only 3.9 percent in 2010, reaching $2.6 trillion or $8,402 per person, just 0.1 percentage point faster than in 2009.

In 2010, as health spending growth remained low, growth in U.S. economy as reflected in gross domestic product (GDP) (4.2 percent) rebounded. As such in 2010, the health spending share of the overall economy was unchanged at 17.9 percent. In the past, this share has increased, rising over time from 5.2 percent in 1960.

"We have worked hard since the passage of the Affordable Care Act in 2010 to lower health care cost growth," said Marilyn Tavenner, acting CMS administrator. "We believe that the tools in health reform will help keep health care cost growth low while improving the value of care for consumers."

Key findings from the new report include:

- Household health care spending equaled $725.5 billion in 2010 and represented 28 percent of total health spending, slightly lower than its 29 percent share in 2007. Growth in total private

health insurance premiums slowed in 2010 to 2.4 percent from 2.6 percent in 2009, continuing a slowdown that began in 2003. Despite this deceleration, for the first time in seven years, the growth in premiums exceeded the growth in insurer spending on health care benefits, with the net cost of insurance increasing by 8.4 percent or $11.3 billion in 2010. Out-of-pocket spending by consumers increased 1.8 percent in 2010, accelerating from 0.2-percent growth in 2009.

- Retail prescription drug spending (10 percent of total health care spending) grew only 1.2 percent to $259.1 billion in 2010, a substantial slowdown from 5.1-percent growth in 2009 and the slowest rate of growth for prescription drug spending recorded in the NHE.

- The federal government financed 29 percent of the nation's health care spending in 2010, an increase of six percentage points from its share in 2007 of 23 percent, and reached $742.7 billion. Part of that increase came from enhanced Federal matching funds for State Medicaid programs under the American Recovery & Reinvestment Act which expired in 2011. Medicare spending grew 5.0 percent in 2010, a deceleration from growth of 7.0 percent in 2009.

- Medicaid spending increased 7.2 percent in 2010, slowing from 8.9-percent growth in 2009.

- The state and local government share of total health spending declined from 18 percent in 2007 to 16 percent in 2010 and totaled $421.1 billion, in part due to the temporary assistance in the Recovery Act.

- Hospital spending, which accounted for roughly 30 percent of total health care spending, grew 4.9 percent to $814.0 billion in 2010, compared to growth of 6.4 percent in 2009.

- Growth in private health insurance spending for hospital services, which in 2010 accounted for 35 percent of all hospital care, slowed considerably in 2010.

- Physician and clinical services spending, which accounted for 20 percent of total health care spending, grew 2.5 percent to reach $515.5 billion in 2010, slowing from 3.3-percent growth in 2009.

- Private businesses financed $534.5 billion, or 21 percent of total health spending in 2010, down from a 23-percent share in 2007.

The NHE report, prepared annually by the Centers for Medicare & Medicaid Services' (CMS) Office of the Actuary, summarizes recent trends in health care spending based on the most current data sources. Available historically since 1960, the NHE represents the official estimates of total health care spending in the United States and measures annual health spending by the types of goods and services delivered (hospital care, physician services, retail prescription drugs, etc.), by the programs and payers that pay for that care (private health insurance, Medicare, Medicaid, etc.), and by the sponsors who are ultimately responsible for financing that care (private business, households, and governments).

Information in this report can be accessed at the following web location: http://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage

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The Washington Post

'Essential benefits' a complex question in new health-care law

By N.C. Aizenman
Washington Post Staff Writer
Friday, January 14, 2011; 8:24 PM

Should health insurers have to cover treatment of Lyme disease? What about speech therapy for autistic children? Or infertility treatments?

Can they limit the number of chemotherapy rounds allowed cancer patients? Or restrict the type of dialysis offered to people with kidney disease?

This week an independent advisory group convened by the Obama administration launched what is likely to be a long and emotional process to answer such questions.

It's hard to overstate the stakes.

Under the new health-care overhaul law, beginning in 2014 all new insurance plans for individuals and small businesses will have to include a package of minimum "essential benefits" falling into 10 general categories - ranging from hospitalization, to prescription drugs, to rehabilitative and habilitative services. But Congress largely left it to Secretary of Health and Human Services Kathleen Sebelius to decide how detailed to make the essential benefits package and what exactly to put in it.

Draw up a package that is too bare-bones, and millions of Americans could be deprived of meaningful health coverage when they need it most - undercutting a central goal of the health-care law. Add in too many expensive benefits and premiums could spike to unaffordable levels.

At a two-day hearing Thursday and Friday held by the Institute of Medicine ,even ardent supporters of the health-care law stressed the dangers of this second scenario: If insurance were to be become too costly, many Americans could decide it makes more sense to pay a penalty rather than comply with the law's requirement that virtually everyone obtain coverage- undermining a cornerstone of the law. Indeed, the law exempts consumers from the mandate to buy insurance if the cost exceeds 8 percent of their income.

The Washington Post

'Essential benefits' a complex question in new health-care law

Also, while poor people would still be able to use federal subsidies to buy plans on state-run marketplaces, the impact on the federal budget could be catastrophic, ultimately dooming one of President Obama's signature legislative achievements.

Jonathan Gruber, a prominent economist who helped create the state plan in Massachusetts, told the panel he estimated that a 10 percent rise in the cost of the essential benefits package would increase the cost of government subsidies by 14.5 percent, or $67 billion, while reducing the share of the insured by 4.5 percent ,or 1.5 million, through 2019.

"That must be the number one thing in your minds," Gruber said. "To understand the trade-off between our desire to make insurance generous and our desire to make it affordable."

The 18-member panel, which includes researchers and physicians as well as representatives of both consumer groups and insurers, has already received more than 300 public comments.

The committee, which aims to offer its recommendations as soon as next fall, is not charged with drawing up a comprehensive list of services to be included in the essential benefits package. Instead, Sebelius has asked it to weigh in on a number of key questions - beginning with how detailed to make the package in the first place.

Speakers representing insurers and employers argued that Sebelius should simply ensure that plans are covering the broad categories already laid out in the law. Otherwise HHS risks micro-managing in ways that interfere with insurers' ability to offer consumers choice and stifle their use of incentives to encourage consumers to control costs.

Some consumer advocates countered that unless HHS spells out the specific services to be covered in each category and prohibits insurers from placing limits on their use, patients could be denied vital care for conditions raging from obesity to kidney disease. "Access to repeated [kidney] transplants should not be limited," pleaded Troy Zimmerman, of the National Kidney Foundation.

The Washington Post

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He and advocates also urged HHS to formally define terms such as "medically necessary," which they warned insurers could otherwise interpret in ways that enable them to deny appropriate care.

"When a 40-year-old obese woman comes to my practice . . .her medical needs dictate that I provide her with obesity education and direct her to nutrition counseling . . . to help her prevent diabetes. But when billed for, these services are usually denied," said Arnold Cohen, Chairman of the Department of Obstetrics and Gynecology at the Albert Einstein Medical Center in Philadelphia.

Also at issue is language in the law directing HHS to ensure that the essential benefits package is comparable to a "typical employer plan." Did Congress mean the benefits-rich plans sponsored by large businesses? The skimpy offerings purchased by many small businesses? Something in between?

Though several current and former congressional staff involved in drafting the law testified, their answers were too varied to give a clear sense of Congress's intent.

The panel also grappled with how much consideration to give existing minimum benefits required by various states.

In some case these mandates stem from the high incidence of a particular disease in that state - lyme disease in Connecticut, for example. But James Dunnigan, a member of the Utah House of Representatives complained that in others "it's a matter of local politics and not necessarily a reflection of what's medically necessary."

States can continue to impose whatever benefits they choose above the minimum essential benefits package. But they will have to cover the extra cost for those plans sold on state-based exchanges.

Dunnigan proposed that HHS allow insurers to offer an essential benefits package that is typical of what employers offer in the given state. Jon Kingsdale, who like Gruber was instrumental in designing the Massachusetts health plan, countered that this would create an workable patchwork of mandates.

After hours of testimony, the panel's

The Washington Post

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chairman John Ball, seemed to find only one point on which everyone could agree: "We have an impossible job."

The Washington Post

Administration to high court: Congress acted within rights on health-care law

By Robert Barnes, Published: January 6

Congress was "well within" its constitutional powers when it decided that the way to resolve a crisis in health-care costs and coverage was to mandate that Americans obtain insurance or pay a fine, the Obama administration told the Supreme Court on Friday.

The government filed its opening brief in the battle over the 2010 health-care overhaul, which has become the most controversial accomplishment of President Obama's domestic agenda. Its resolution will define the court's term.

Solicitor General Donald B. Verrilli Jr. told the court in his initial filing involving the "individual mandate" that the Constitution gives Congress vast powers to regulate economic activity and resolve a "crisis" in the national health-care market.

Lawmakers decided that requiring health insurance was the best solution "after years of careful consideration and after a vigorous national debate," Verrilli told the court.

"That was a policy choice the Constitution entrusts the democratically accountable branches to make, and the court should respect it."

The brief echoed the themes the administration has sounded in defending the Affordable Care Act through legal challenges throughout the country. But the new brief seemed to more fully embrace the argument that the act was also justified by Congress's taxing powers.

Supporters of the legislation were more reluctant at the time it was passed to refer to the fines that would be levied on those who failed to obtain health insurance as a tax.

"That Congress used the word 'penalty' in the minimum coverage provision, rather than 'tax' is immaterial to whether it was a proper exercise of Congress's power over taxation," Verrilli wrote.

The court has scheduled $5^1/_2$ hours of oral arguments in the case over three days, March 26-28. Friday was the initial deadline for briefs on some aspects of the case. In separate filings, those challenging the law — the National Federation of Independent Business and Florida and 25 other states — argued that if the court struck the individual mandate, the entire law must fall.

The individual insurance requirement is the most controversial part of the law. Lower courts that have examined the issue have split on whether the Constitution gives Congress the power to require individuals to buy something they may not necessarily want.

A panel of the U.S. Court of Appeals for the 11th Circuit in Atlanta said that was too much, calling it a "wholly novel and potentially unbounded assertion of congressional authority."

"We are unable to conceive of any product whose purchase Congress could not mandate under this line of argument," wrote Chief Judge Joel Dubina and Circuit Judge Frank Hull.

But other appeals courts upheld the individual mandate as a political decision that was up to Congress and the executive branch, not subject to the second-guessing of the judicial branch. One appeals court said it was not the right time to decide the constitutionality of the mandate, which does not go into effect until 2014.

The three 11th Circuit cases accepted by the court are *National Federation of Independent Business v. Sebelius*; *Florida, et al., v. Department of Health and Human Services*; and *Department of Health and Human Services v. Florida, et al.*